

**CLIENT AGREEMENT & STATEMENT OF CONFIDENTIALITY**

**CONSENT FOR TREATMENT:**

**I hereby give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be evaluated by means of interview. I further authorize Karen Hall LCSW, PA to treat said client by means of psychotherapy, counseling, behavior therapy, and/or other procedures as may be indicated. It is understood that the materials and information obtained will be treated confidentially within the constraints given below.**

**CONFIDENTIALITY:**

**The materials and information obtained during the course of therapy, evaluation, consultation or other mental health services will be treated confidentially by Karen Hall LCSW, PA subject to the following limitations: (1) unless you request release in writing; (2) your insurance carrier requests information to assist in payment for services; (3) Circuit Court order is presented; (4) information must be released by mental health professionals in response to legal requirements to report suspected child abuse or abuse of the elderly, suicidal or homicidal intent; (5) automated voice/phone equipment may be utilized to inform and remind clients of appointment; (6) as otherwise required by law.**

**In order to assure proper confidentiality, client files are accessible only to the staff members who use the file for treatment, payment and health care operations as outlined in the Notice of Privacy Practice, review purposes and adhere to alcohol/drug confidentiality guidelines as outlined in 42CFR Part 2. Our privacy notice provides information about how we use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If changed, you may receive a copy from the Office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.**

**You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.**

**FEES:**

**I understand that I am personally responsible for the cost of services that I will receive from Karen Hall LCSW, PA and that I may use a third party source to satisfy my bill. In the event I am not eligible for a third party pay source, or the office does not collect from the third party, I understand that I am personally responsible for the cost of these services. Charges will include non-direct time, such as report writing, treatment plan and any court time if necessary.**

**If I have insurance, I authorize payment of insurance benefits to go directly to Karen Hall LCSW, PA and also the release of the necessary information to proceed with this claim.**

**CONSENTS:**

**I also consent for Karen Hall LCSW, PA to exchange and access information with my primary care physician and school regarding diagnosis (including drug and/or alcohol information, if applicable), intake, treatment plan/recommendations, current medication progress note including prescribed medications and any other relevant information that may be needed to maintain continuity of care.**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PCP Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***I HEARBY ACKNOWLEDGE RECEIPT OF INFORMATION PERTAINNING TO THE CONFIDENTIALITY OF MY RECORDS, NOTICE OF PRIVACY PRACTICES, OUTPATIENT GUIDELINES AND BILL OF RIGHTS.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Client Social Security Number Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian (or Parent, if minor) Relationship Witness Date**



**Notice of Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

**PLEASE REVIEW THIS NOTICE CAREFULLY**

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your therapist or one of the office's employees.

# **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, we have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways we are committed to use and disclose your "PHI" will fit within one of these general categories:

1. For Treatment. "*Treatment*" is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
2. For Payment. "*Payment*" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. We may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
3. For Healthcare Operations. "*Healthcare Operations*" are activities that related to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. We may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, post cards, and other mailings.
4. Use. "*Use*" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
5. Disclosure. “*Disclosure*” applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

# **III. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse. If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.
2. Adult and Domestic Abuse. If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
3. Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
4. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your PHI to defend the office or to respond to a court order.
5. Law Enforcement. We may release PHI about you if required by law when asked to do so by a law enforcement official.
6. Serious Threat to Health or Safety. If you communicate to us a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.
7. Worker’s Compensation. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. Patient’s Rights and Psychotherapist’s Duties

You have the following rights regarding the PHI that this office maintains about you.

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at our office. On your request, we will send your bills to another address.) To request confidential communications, you must complete our request form in writing and submit it to the Privacy Officer. We will accommodate all reasonable requests.
3. Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete our request form and submit it to the Privacy Officer. If you request copies, we will charge you $0.25 per page. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
4. Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must complete our request form and submit it in writing to the privacy officer. In addition, you must provide a reason that supports your request. We may deny your request. On your request, we will discuss with you the details of the amendment process.
5. Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003.
6. Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from us upon request.

Psychotherapist’s Duties:

1. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
2. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

# **V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact the Privacy Officer at Psychological Consultants listed below.

If you believe that your privacy rights have been violated and wish to file a complaint with us/our office, you may send your written complaint to the Privacy Officer at Psychological Consultants. All complaints must be submitted in writing to:

Privacy Officer:

Karen Hall LCSW, PA

2210 W. Kingshighway Suite 3

Paragould AR 72450

870-236-2265

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

# **VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice in this office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.



**ACKNOWLEDGMENT OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy

of this office's Notice of Privacy Practices form.

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Patient/ Parent/Guardian Signature Date

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Print Patient Name Date

**Demographic Sheet**

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| **Name:** | | | | | | **Social Security Number:** | | | | | | | **Date:** | | |
| **Client Information Unless Otherwise Noted:** | | | | | | **City** | | **State** | | | | | | **Zip** | |
| **Physical Address:** | | | | | |  | |  | | | | | |  | |
| **Mailing Address: Same as above** | | | | | |  | |  | | | | | |  | |
| **County of Legal Residence:** | | | | | | | | **Out of State** | | | | | | **Unknown** | |
| **Living Situation: Private Residence Foster Home Other (please list)** | | | | | | | | | | | | | | | |
| **DOB:**  **\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  **(m /d /year)** | | | | **Client Age:** | | | **Gender:**  **Male Female** | | | **Social Security No:**  \_ \_ | | | | | |
| **Home Phone:**  **( )** | | | | **Work Phone**  **( )** | | | | | **Other Phone Message or Cell**  **( )** | | | | | | |
| **Marital Status:**  **Married Single Divorced Widow Separated Other:** | | | | | | | | | | | **Number of Children:** | | | | |
| **Race** | **(Check any/all that apply) Alaskan Native/American Indian Asian**  **White Black/African American Native Hawaiian/Other Pacific Islander** | | | | | | | | | | | | | | |
| **Ethnicity: Hispanic or Latino Not Hispanic or Latino** | | | | | | | | | | | | | | |  |
| **Primary Language: English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **Currently enrolled in school? Where?** | | | | | | | | | | | | | | | |
| **Employment Status: Employed, Full Time Part Time Unemployed**  **Not in Labor Force ( Student, Retired, Sheltered Employment, Homemaker, Volunteer, Disabled)** | | | | | | | | | | | | | | | |
| **Place of Employment:** | | | | | | | | | | | | | | | |
| **Emergency Contact**  **Name and Address** | | Home/work **( )**  Cell/contact **( )**    **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| **Payment Source:** | | | **Self** **Self/Insurance** **Workers Comp EAP** | | | | | | | | | | | | |
| **Primary Insurance Name:** | | | | | **Insurance Plan No:**  **Subscriber’s Date of Birth:**  **Subscriber’s SS #:** | | | | | | | **Group #:** | | | |
| **Secondary Insurance Name:** | | | | | **Insurance Plan No:**  **Subscriber’s Date of Birth:**  **Subscriber’s SS #:** | | | | | | | **Group #:** | | | |
| **EAP Involved/Eligible:** | | | | | **Company Name of Primary Insurance:** | | | | | | | **Company Name of Secondary:** | | | |

**ADULT SELF ASSESSMENT**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **FAMILY AND SOCIAL LIFE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Household Members – Please list everyone who lives in your home** | | | | | |
| **Name** | **Age** | | **Relationship** | | |
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| **Family Relationships – Please rate how big a problem each issue is in your family** | | | | | |
| **Issue** | | **No Problem** | | **Little Problem** | **Big Problem** |
| **Concerns about the place where you live** | |  | |  |  |
| **Concerns about how you get along with others** | |  | |  |  |
| **Parents working together to raise a child** | |  | |  |  |
| **Worries about spirituality or religion** | |  | |  |  |
| **Sexual orientation issues** | |  | |  |  |
| **Alcohol or drug use issues in the home** | |  | |  |  |
| **Other addictions in the home** | |  | |  |  |
| **Worries about basic needs like food and clothing** | |  | |  |  |
| **Trouble getting places where you need to go** | |  | |  |  |
| **Difficulties regarding legal concerns** | |  | |  |  |
| **Comments:** | | | | | |
| **Family’s Religious Preference:** | | | | | |

1. **EDUCATION, EMPLOYMENT AND MILITARY INFORMATION**

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| --- |
| **Education History (Check All That Apply): GED HS Grad College-#Years \_\_\_\_Degree/Major**  **Other Degree:**  **Highest Grade Completed Vocational Year Completed** |
| **History of Learning Difficulties: Learning Disability - Type:**  **None Reported Mental Retardation:**  **Special School Placement:**  **Other:** |
| **Barriers to Learning: Inability To Read or Write:**  **None Reported Other:** |
| **If Employed, Name of Employer:** |
| **Job Performance History: Number Of Jobs in the Last 5 Years \_\_\_\_\_\_\_\_\_\_\_**  **Attendance: Above Average Normal Tardiness Absenteeism**  **Performance: Above Average Normal Tardiness Absenteeism** |
| **Employment Interests/Skills:**  **Are you satisfied with your job? No Yes**  **Are you experiencing financial problems? No Yes**  **(If not currently employed) – Do you want to work? No Yes**  **Are you concerned that employment will affect benefits? No Yes** |
| **Military History:**  **No Yes If yes, describe branch of service, any pertinent duties and any trauma experienced during service as applicable:**  **National Guard/Reserves Army Navy Air Force Marines Coast Guard Other Type of Discharge, if other than General/Honorable: Date of Discharge and Rank at Discharge:** |

1. **HEALTH AND SAFETY**

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| **Medical History** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Care Physician** |  | | | | | | | | | | | | | | | | | | **Phone:** | | | | | |
| **Physician/Clinic Address** |  | | | | | | | | | | | | | | | | | | **City:** | | | | | |
| **When did you last see your physician?** | | | | | | | | | | | | | **For what reason?** | | | | | | | | | | | |
| **Are you currently pregnant / nursing?** | | | **Yes** | | | | | **No** | | | | | | | | | | | | | | | | |
| **SECTION 1: Please check “Yes” or “No” for each item: Have you ever Had? Yes No** | | | | | | | | | | | | | | | | | | | | | | | | |
| **A disorder of eyes, ears, nose or throat?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Dizziness, fainting, headache, seizure, convulsions, paralysis, stroke, head trauma (with or without loss of consciousness) or other neurological disease?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Persistent coughing, bronchitis, asthma, emphysema, tuberculosis, or other disorder of your lungs?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Chest pain, high blood pressure, rheumatic fever, murmur, heart attack, other disorder of the heart/blood vessels?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Intestinal bleeding, ulcer, hernia, colitis, other disorder of the stomach, intestines, liver (e.g. hepatitis) or gallbladder?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Disorder of kidney, bladder, prostate, reproductive system including HIV or other sexually transmitted diseases?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Diabetes, thyroid, or other endocrine disorders?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **Arthritis or other disorder of the muscles or bones, including the spine, back or joints?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **A tumor, cancer, or disorder of skin or lymph glands?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **If sexually active, do you use a condom and/or means of birth control?** | | | | | | | | | | | | | | | | | | | |  | |  | | |
| **If you are experiencing pain, please rate: No Pain** | | | | | | | **1** | | | **2** | | **3** | | | **4** | | **5** | **Most Severe Pain Imaginable** | | | | | | |
| **SECTION 2: Do you have Medication allergies?** | | | | | **NO** | | | | | | **YES If yes, indicate types below** | | | | | | | | | | | | | |
| **Specify Types:** | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 3: Do the following occur frequently?** | | | | **YES** | | **NO** | | |  | | | | | | | | | | | | **YES** | | **NO** | |
| **Headaches?** | | | |  | |  | | | **Frequent, difficult or painful urination?** | | | | | | | | | | | |  | |  | |
| **Hoarse throat?** | | | |  | |  | | | **Menstrual pain?** | | | | | | | | | | | |  | |  | |
| **Ear infections/plugging/pain?** | | | |  | |  | | | **Abdominal pain/flank pain?** | | | | | | | | | | | |  | |  | |
| **Fainting spells or balance problems?** | | | |  | |  | | | **Nausea/vomiting?** | | | | | | | | | | | |  | |  | |
| **Breathing problems/cough?** | | | |  | |  | | | **Easy bruising or unusual bleeding?** | | | | | | | | | | | |  | |  | |
| **Fevers?** | | | |  | |  | | | **Joint/muscle pain?** | | | | | | | | | | | |  | |  | |
| **Chest pain?** | | | |  | |  | | |  | | | | | | | | | | | |  | |  | |
| **Have you been treated for any of the conditions checked in Section 1 and 2 Yes No** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Which conditions?** | | **Who Treated you?** | | | | | | | | | | | | | | **When?** | | | | | | | | |
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| **Do you have any disability restrictions because of these conditions? Yes No** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Condition:** | | | **Restrictions:** | | | | | | | | | | | | | | | | | | | | | |
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| 1. **HEALTH AND SAFETY (**Continued) | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you ever been under the care of any other Therapist or Psychiatrist? Yes No** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name and Address** | | | | | | | | | | | | | | **When** | | | | | | | | | | |
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| **Do you currently use: Alcohol? Tobacco? Injected drugs? Caffeine?**  **Non-prescription drugs or herbal remedies?** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contagious Illnesses: As far as you are aware, do you currently have any contagious illnesses? Yes No** | | | | | | | | | | | | | | | | | | | | | | | | |
| **If yes, what symptoms?** | | | | | | | | | | | | | | | | | | | | | | | | |

1. **NUTRITIONAL INFORMATION**

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| --- | --- |
| **How many meals do you eat a day?** | |
| **Give examples of what you would eat in a normal day (include snacks):** | |
| **Do you consider yourself to be: Underweight Overweight Average How many pounds?** | |
| **Are you on any special diet? Yes No**  **Explain:** | |
| **How has your weight changed in the past six (6) months?** | |
| **Do you have problems with: Chewing Swallowing Choking Nausea Binge eating**  **Purging (purposeful vomiting) None of these** | |
| **Is there anything else about your medical history or health and safety issues that you would like to tell us about?** | |
| **What prompted you to seek treatment at this time?** | |
| **Any additional information you feel may be helpful for the therapist to be aware of:** | |
| **Signature Of Person Completing the Form:** | **Date:** |
| **Relationship to the Client:** | **Signature of Client (if not completing form)** |

**Medication Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Current Medication you are taking.** | | | | | | |
| **Name of Medication:**  **What date did you start taking this medication?** | **Dose:** | **When Taken:** | | **For What:** | **Prescribed by?** | **Does the Medication seem to be Working?** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
|  |  |  | |  |  | **Yes No** |
| **Past Medications for Mental Health.** | | | | | | |
| **Name of Medication and End Date** | | | **Reason For Discontinuation:** | | | |
|  | | |  | | | |
|  | | |  | | | |
|  | | |  | | | |
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**2210 West Kingshighway, Suite 3**

**Paragould, AR 72450**

**(870) 236-2265**

**Fax (870) 215-0772**

Effective March 1, 2013:

If unable to keep an appointment,

kindly give a 24 hour notice.

If not, there will be a fee of $35.00.

(This fee cannot be charged to your Insurance.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

\* It is against office policy for Karen Hall, LCSW or staff to have any social media contact with patients and/or parents. Please understand we love our patients but cannot provide good care for them through any social media source or texting. We appreciate your understanding in this matter.

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Depression Symptom Checklist**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | **Does Symptom Currently Apply to You? X if “Yes”** | **Severity \* (1-10)** | **How Often Does This Symptom Occur?** |
| 1. Low mood almost every day or part of every day for at least 2 weeks |  |  |  |
| 1. Lack of interest in activities that were once pleasurable |  |  |  |
| 1. Weight loss or gain (not from dieting) of 5% of body weight |  |  |  |
| 1. Difficulty falling or staying asleep or early awakening nearly every night |  |  |  |
| 1. Sluggishness or physical tension almost every day |  |  |  |
| 1. Fatigue or low energy almost every day |  |  |  |
| 1. Low self-esteem and a sense of worthlessness or guilt |  |  |  |
| 1. Chronic difficulty making decisions, thinking clearly, and /or keeping focused |  |  |  |
| 1. Repetitive thoughts of death and suicide and/or plans or commit suicide |  |  |  |
| 1. Symptoms seem to be worse in the morning, including often waking up to early |  |  |  |

\*1=almost nonexistent in my life

5=applies to me about half of the time

10=very relevant to my condition

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Symptom Checklist

Maximum level of anxiety (circle a number below).

0-----1-------2-------3--------4--------5-------6-------7------8---------9-------10

None Mild Moderate Strong Extreme

Indicate which of the following symptoms you are experiencing:

Restlessness, feeling keyed up or on edge \_\_\_\_\_\_\_\_\_

Easily fatigued \_\_\_\_\_\_\_\_\_

Difficulty concentration or mind going blank \_\_\_\_\_\_\_\_\_

Irritability \_\_\_\_\_\_\_\_\_

Muscle tension \_\_\_\_\_\_\_\_\_

Sleep disturbance \_\_\_\_\_\_\_\_\_

Appetite disturbance \_\_\_\_\_\_\_\_\_

A period of intense fear or discomfort \_\_\_\_\_\_\_\_\_

Triggering events: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxious thoughts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxious behaviors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_